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RHODE ISLAND PROPSECTIVE RATING PROGRAM

DESCRIPTION OF THE PROGRAM

SECTION B

I. Objectives

Said program is designed to conform with mandates prescribed in Chapter 19, Title 27 of the laws of Rhode Island as it affects hospital reimbursement and budget review.

II. Features and Procedures of the Program

A. The Statewide MAXICAP

For said year a total operating expense limit (CAP) will be negotiated between the parties as outlined in Section II C and II D. The intent of the CAP is to establish an outside limitation on total hospital operating expenditures for a fiscal year excluding expenses associated with professional components and activities financed by grants and contracts. In concept, the CAP is not intended as a target, but rather as an outside limitation on budgeted hospital expenditures for Rhode Island. Below the aggregate ceiling of the CAP, the parties will be free to negotiate hospital budgets. While individual hospital budgets may be settled without regard to the limit imposed by the CAP, in the final analysis, the aggregate total of all hospital expense budgets in the State may not exceed this ceiling.



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The CAP will contain provisions for all hospital budgeted expenditures, including salary and wages, supplies expense, fringe benefits, new and expanded medical and non-medical programs, volume changes, and any other factors impacting hospital costs, excluding expenses associated with professional components and activities financed by grants and contracts.

If the volume corridor provisions as described in Section II M result in the MAXICAP being exceeded, such excess will be allowable subject to third-party audit review at year end settlement that the corridors were complied with. If the granting of major contingencies as described in Section II P result in the MAXICAP being exceeded, such excess will be allowable subject to third-party confirmation that major contingencies have been granted.

B. Base of Cap

For the 79-80 fiscal year the base will be the 1973-74 actual hospital expense X the final 1974-75 MAXICAP X the final 1975-76 MAXICAP X the final 1976-77 MAXICAP X the final 1977-78 MAXICAP X the final 1978-79 MAXICAP. The base will be adjusted for the operation of the volume corridors and agreed to or granted, recurring major contingencies subject to validation of the data within the context of the process described in Section II Q. In future years the same methodology will be applied.

C. State CAP Committees

By April of each year, a committee shall be formed for the express purpose of negotiating a proposed statewide CAP for the next fiscal



R 4 Tr. 7/12/79 Incorp. 7/23/79 Effective 10-1-79

year scheduled to begin on October 1 (reference Timetable Section II F). This committee will be composed of representatives from each of the following organizations:

1. Blue Cross of Rhode Island
2. Budget Office of the State of Rhode Island
3. Hospital Association of Rhode Island

Agreement on the proposed Statewide CAP must be unanimous by all of the parties cited above.

D. Program/Review - Planning Process

It is the intent of all parties to utilize the Medical Program Review Process as outlined in Exhibit A. Under this process, hospitals shall submit program plans that exceed predetermined dollar criteria to the voluntary Health Planning Council. The Health Planning Council will evaluate these plans in terms of community need and gives a priority rating in accordance with the merits of each program in accordance with established criteria and its compatibility with overall community objectives. The Planning Council's recommendation shall then be transmitted to Blue Cross and the State and the hospitals for consideration in budget negotiations.

All medical programs submitted to HPC for review will be categorized as either Priority I, II, or III, in accordance with the priority grading system outlined in Exhibit A. Priority I programs will be ranked in order of the desirability of their implementation. Medical programs will then become subject to the budget negotiating process.

A full outline of the Medical Program Review Process is contained in Exhibit A. Medical programs not subject to the HPC review, and non-medical programs will be subject to the appropriate processes outlined in Exhibit A.

With respect to HPC programs contained within the budget, the implementation date, dollar impact and carry over expense will be negotiated.

E. Budget Preparation, Review, and Negotiations

The hospital shall establish and furnish in advance a Board reviewed-budget for its next fiscal year. (Attachment 1) It will include the total budgeted operating expenses, revenues and statistics. Prior to the beginning of each fiscal period, each hospital agrees to submit its detailed financial and statistical budgets, in a format agreed to between the State, Blue Cross, and the Hospital Association, in accordance with the timetable as outlined in Section II F.

1. Review and Negotiation

For the negotiations, hospital budgets will be submitted to Blue Cross. Each hospital will meet with the State Budget Office and Blue Cross for the purpose of negotiating a total operating expense budget for the ensuing fiscal year.

2. Individual Hospital Base

The base for individual hospital negotiations will be the lower of actual hospital expenses or agreed on budget which includes the results of the volume corridor adjustments and major contingencies. If a major contingency is granted to an individual hospital, and during the negotiations of the contingency there is a mutual agreement between the parties that the

contingency does not have a carry over impact, then the contingency will not be included in the hospital's base.

F. Timetable

The timetable for each fiscal year will be as follows:

1. Submission of medical programs to HPC 3/1
   It is understood that this date is a deadline and programs will not be considered after said date unless waiver is granted by the Third Parties.
2. Negotiations of the statewide MAXICAP 4/1-4/30
3. MAXICAP mediation and arbitration if necessary
   Mediation to be completed by 5/15
   Arbitration to follow the 5/15 date
4. Results of Medical Program Reviews from HPC to be known by 4/30
5. Individual hospital budget package submissions will be submitted by 6/15
6. Individual hospital budget negotiations to be completed by 8/15
7. Mediation of individual hospital budgets to be completed by 8/31
8. Cost finding to be submitted by hospitals by 10/1, or in 30 days from the date the hospital received the rate determination package, following an agreed on budget, should such date be after 9/1. Blue Cross and the State will have 20 working days for review and acceptance of

the proposed RCC rates provided the hospital has submitted a complete rate determination package and answered all questions.

G. Allowable Costs

The elements of allowable costs for determining prospective rates under this contract will be those which currently apply for each particular purchaser of care. For Blue Cross the elements will be the same as those embodied in the present Blue Cross of Rhode Island Contract with Member Hospitals of October 1, 1973. For the various participating State programs, they will be consistent with the application of the Medicare principles of reimbursement.

H. Lower of Cost or Charges

The lower of cost or charge provision will be applied prospectively to all third parties in accordance with the principles of reimbursement applicable to each third party. For Blue Cross reimbursement, there will be four (4) separate tests as outlined in Section 2.11 of the Blue Cross of Rhode Island Contract with Member Hospitals of October 1973. For Medicaid the provisions contained in the Federal Register of May 10 1974 and August 6, 1974 respectively will apply.

I. COASAL or MICAH Submission

At the conclusion of each hospital's budget negotiations, the total operating expense budget of the hospital and statistics for the ensuing fiscal year, as determined and agreed upon in accordance with the above described process, shall be submitted to prospective cost finding through the Cost Allocation Program of HARICOMP, Inc. (COSAL) or the

MICAH Corporation of Ann Arbor, Michigan, or any other mutually agreed on cost package. Copies of MICAH, COSAL, or any other mutually agreed on cost package, input documents and output reports shall be available for review by all parties to this agreement.

J. Rate Determination

Each purchaser of care will be responsible on a prospective basis to continue payment for hospital services consistent with present "principles of reimbursement" as defined for each purchaser, except where such principles are changed by an appropriate process. Such principles are defined in Section II G. After a hospital budget has been agreed to, the hospital will be expected to process its budget through cost finding in accordance with the timeframe outlined in Section II F of this agreement. Each hospital will either perform separate cost findings for each major third party purchaser in conformance with the principles of costs applicable as defined in Section II G; or they will make the appropriate adjustments to a single cost finding to properly reflect the principles involved.

As a by-product of the cost finding process, ratios of allowable costs to hospital charges (RCC) will be established for two reimbursement categories: Inpatient Care and Outpatient Care. Thus, two RCC rates will exist for each third party purchaser. RCC's will be based on the pertinent relationship of allowable costs for each purchaser to the hospital board approved charges by category (i.e. inpatient and outpatient).

K. Hospital Charges

Each hospital will be free to establish a schedule of hospital board approved charges once during the fiscal year. The schedule must be provided at the beginning of the fiscal year and include a full list of charges for both routine and ancillaries and the date(s) of implementation. Hospitals agree to guarantee their charge structure as determined for the budgeted fiscal year. However, it is understood that a hospital would be free to change its charge structure following the granting of a major contingency adjustment to the agreed upon budget.

L. Year End Adjustments (Attachment 4)

The following provisions will apply but will be handled as a year-end settlement and not be incorporated as a factor in formulating prospective rates.

a. Blue Cross Free Care and Bad Debts as outlined in Appendix I of the October 1973 Blue Cross of Rhode Island Contract with Member Hospitals.

b. Blue Cross and the State's share of the Medicare 8-1/2% Nursing Care Differential. Such differential will be based on actual data as determined at the end of the fiscal year.

3. Any adjustments needed to bring hospital reimbursement into line with adjustments as described in Section II M and N.

M. Volume and Intensity Provisions

The basic purpose of these provisions is to encourage less costly forms of health care, other than inpatient care, i.e. ambulatory care, home care, and pre-admission testing.

Thus the intent of the parties is to design volume and intensity provisions that would be both simple to administer and place the incentive on a hospital to optimally use its facility. The basic assumption on the inpatient side is that hospitals should be reimbursed for increased or decreased volume only in relation to the fixed costs when activity is decreasing, or to the extent that variable or marginal costs increase as volume increases.

## VOLUME CORRIDORS

1. ROUTINE INPATIENT CORRIDOR

| CHANGE FROM BUDGETED DAYS | PORTION OF BUDGETED PER DIEM: RETAINED BY HOSPITAL* | REFUNDED TO 3RD PARTIES |
|---|---|---|
| + 0-5% | 20% | 80% |
| + 5-7% | 30% | 70% |
| + 7-10% | 40% | 60% |
| 10% | NEGOTIABLE | NEGOTIABLE |

| CHANGE FROM BUDGETED DAYS | PORTION OF BUDGETED PER DIEM: PAID TO HOSPITAL | NOT BILLED TO 3RD PARTIES |
|---|---|---|
| - 0-5% | 80% | 20% |
| -5-7% | 70% | 30% |
| -7-10% | 60% | 40% |
| -10% | NEGOTIABLE | NEGOTIABLE |

* ALSO EQUALS PORTION OF ROUTINE VOLUME ADDED TO EXPENSE BASE

The revenue in the above context means agreed upon budgeted revenue for inpatient routine services.

There will be a separate nursery day corridor for Women and Infants Hospital only. Otherwise, there is no corridor for nursery days.

The above adjustments apply to both revenues and the expense base; however, no negative adjustments will be made to the expense base.

2. INPATIENT ANCILLARY ADJUSTMENTS

These adjustments are designed to protect hospitals and the Third Parties from unexpected volume fluctuations. It should be noted that the Professional Component for direct patient care is not included in the ancillary adjustments. These adjustments apply to ancillary revenue (subject to the applicable overall R.C.C.) and will apply in the following manner.

To the extent that a hospital can demonstrate that pre-admission testing was performed on inpatients, the amount of such pre-admission testing will be considered as an outpatient service.

CASE A: IF ACTUAL INPATIENT ANCILLARY REVENUE EXCEEDS BUDGETED INPATIENT ANCILLARY REVENUE, THEN:

1. BUDGETED REVENUE X 1.01 = ADJUSTED BUDGETED REVENUE

2. ACTUAL REVENUE MINUS ADJUSTED BUDGETED REVENUE EQUALS ANCILLARY REVENUE EXCESS